

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 22, 2002
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Reviewing the SGR update for 2003

-- Kevin Hayes

DR. HAYES: Part of the reason for spending just one meeting on this would be that the Commission, as you know, has recommended that the Congress replace the SGR system. In the interim here we are required, nonetheless, to review this early estimate from CMS and put a review of it in our June report. So that's what we're here to do.

So if we look at our next slide we will see some of the details of CMS's preliminary estimate. I would draw your attention to two numbers here. The first is the bottom line, the update estimate, which is a reduction in payments of 5.7 percent. That comes on the heels of a reduction that occurred this year in 2002 or 5.4 percent.

The other important number on this slide has to do with that update adjustment factor that you see there of minus 7 percent. That is the maximum reduction that is permitted under current law. That same thing happened this year for 2002 where we had a maximum reduction of 7 percent. So the question becomes, why is the system continuing to hit these maximums?

The next slide tells the story. What you see here is two lines. The orange line shows actual spending for physician services over time and the black line shows the target that is determined by the so-called sustainable growth rate.

As you can see here, actual spending started to go up faster than the target in 1999 and that continued through 2001. That difference doesn't necessarily mean that actual spending was too high. It just means that actual spending differed from the target. The Commission is on record saying that the target as it is currently determined by the growth in real GDP, gross domestic product per capita, that that kind of a target is too low. But nonetheless, because there is this difference between actual and target spending there is a requirement for a reduction in payments.

MR. HACKBARTH: Last year when we had this conversation we thought the orange line was below the black line for those years, '99, 2000, 2001. In fact for '99 and 2000 there were substantial updates in the conversion factor based on the assumption that the orange line was below the black line. So that's where the things -- the picture, the drawing has changed a lot in the last 12 months.

DR. HAYES: That's right. Reasons for that are first that the economy has slowed down. We now have a report of a recession, in 2001 anyway, and the Department of Commerce revised its estimates of historical real GDP. That too resulted in lower estimates of growth in GDP. A third factor has to do with a rise in actual spending. CMS failed to consider some billing codes when totally up actual spending in earlier years, '98 through 2000. When they finally discovered the problem last year, put that actual spending back into the calculations, we see the kind of a rise that -- contributes to the rise that you see here.

A couple of things to point out about this which shine a

light on how the SGR system works. The first thing is that you can see here, if we project out what will happen under this system over time you can see that it's not enough for actual spending to come back down to the target. Actual spending must be driven below the target for a period of time so that the overspending, so to speak, excess spending, whatever you want to call it, that occurred from '99 through 2003, that spending needs to be recouped somehow. So the way that this system does that is to drive actual spending below the target for a period of time.

You see two areas here. You see one area that's above the target bounded by actual spending above, and then another area to the right which is spending below the target. Eventually those two areas must be equal in order for the system to achieve the balance that it's trying to achieve.

MR. MULLER: How does that curve compare to the \$40 billion estimate of a freeze that either Glenn or Murray referenced yesterday? Would the orange be tracking the black? Is that a freeze or not?

DR. HAYES: No. We'll get in a second to another slide which will show us what this implies in terms of the updates. But the short answer to your question is that, no, this is not a freeze situation.

DR. ROSS: Kevin, can I just interrupt for one second? That \$40 billion, Kevin just said that those two areas above and below the curve need to be equal. The \$40 billion would be the difference by which they were not equal. You didn't recoup all of the spending above the target in the earlier years.

MR. MULLER: That's what I was asking. So in other words, that gap in some -- if the orange at '03 had tracked the black until '09, that's \$40 billion?

DR. ROSS: A part of that.

DR. HAYES: Let me just make one more point about this slide and then we'll get on to what's going to happen to the updates. What you can see here is a relatively gradual process that's happening and that's because the system is hitting those maximum reductions that I mentioned earlier of minus 7 percent. So the effect of that process, of those limits, is to spread this rebalancing of actual and target payments out over a period of years. Of course, a much sharper reduction occurring in any year would cause this process to move much more rapidly, but then you'd have a sharp, sharp dropoff in payment rates.

So what does this mean then? Let's go to the next slide and get at Ralph's question about the \$40 billion. This shows what we can anticipate from the SGR system out into the future. What you see here is a series of very steep reductions through 2004, and then another smaller reduction in 2005. If those reductions went away, of course, that's what would cost \$40 billion, if you were to just flat-line the update and eliminate those reductions.

The total effect of those reductions would be about 17 percent for the period 2002 through 2005. We can contrast that with what MedPAC's proposal implies. Joe correctly pointed out yesterday that we don't know exactly what would happen under MedPAC's proposal because the Congress could step in in any given year and change the update. But what's shown here is an

assumption that the updates equal the change in input prices minus an adjustment for productivity growth of 45 --

MR. HACKBARTH: In fact it goes beyond, Kevin, doesn't it, the Congress stepping in? Under our proposal we do our payment adequacy analysis, so without changing our recommendation we could say at any given year, we have evidence that the rates are too high or too low, so the right answer for this year is not MEI minus one-half of 1 percent.

DR. REISCHAUER: Kevin, did we find out why the actuaries thought that our recommendation, which would increase physician payments, would stimulate volume and intensity?

DR. HAYES: We asked them that question and the thought is that the presence of a target mechanism has served to dampen growth in the volume of services, and if we were to remove that target mechanism that volume would somehow rise.

MS. ROSENBLATT: I just wonder if we're putting a different interpretation on what they're saying, because if you look at the long term projections the SGR mechanism right now has a certain effect on those long term projections; that you don't need to worry about utilization because you've got a mechanism that controls it.

DR. ROSS: Controls spending.

MS. ROSENBLATT: I'm using the wrong words. You're right.

MR. HACKBARTH: What Kevin said is what they said. He's repeating their explanation that they believe that the existence of the mechanism has the effect of reducing volume. Not just controlling spending but reducing volume.

DR. HAYES: That's right.

MR. HACKBARTH: Now by what logic they arrive at that conclusion, I don't know, but that's what they --

DR. NEWHOUSE: That's only if you take it back to the individual physician level and you think there's some relationship between the fee and what the physician does. Then it's whether the fee goes up or whether the fee goes down, they increase volume, it sounds like is the answer.

MR. MULLER: Joe, I'd just say, we now know how to define integrated delivery system.

MS. ROSENBLATT: I'm sorry, just one thing because I think -- Ariel, maybe you can help me, but I think when that panel actually looked at a study it did show that. I think there was some data.

DR. NEWHOUSE: The data showed that when the fee went down, the services went up, and when the fee went up, the services went down, not up. Hence, Bob's question. That was why we missed in the volume offset estimates when we put in the RBRVS -- and Alan will probably remember -- and the miss was then in part because all the data we had were pretty much for fee reduction. We didn't have the data on what happened with fees increasing. But in fact several of the fees did increase and that accounted for an error.

DR. HAYES: Just one more slide and a few more points here. Returning now to CMS's estimate for 2003 we see no reason to question its accuracy because the reduction that we're looking at for 2003 is kind of sandwiched in between two maximum reductions

that would be required under the SGR system. It seems likely that that would occur if the system remains in place.

The more important point that we wanted to make in the report was that the system is flawed and the Congress needs to repeal it. Staff propose to include a few paragraphs in the report to the effect and we sent you those before the meeting. If there's any feedback on that material we'd be happy to hear about it.

MR. HACKBARTH: Comments? Questions?

DR. ROWE: I had seen in the press a number of a 17 percent reduction over the next several years in physician payments. I don't know if that was an accurate -- that is the sum of this area under --

DR. NEWHOUSE: It's the sum of the these --

MR. HACKBARTH: If you look at this graph.

DR. ROWE: That's 17 percent? Okay.

DR. REISCHAUER: Actually the graph, not to be picky here, looks -- we have 5.4, 5.7, then something that looks like 6 and something that looks like about 1.7, which if I compounded it would get me close to 20 my guess is.

DR. NEWHOUSE: No, not 20. It goes the other direction.

DR. REISCHAUER: Okay, so it's getting smaller.

MS. ROSENBLATT: Jack made a real good point yesterday about the impact of this on commercial premiums. I'm just wondering if it's worth making that point.

MR. HACKBARTH: Elaborate on that, the impact on commercial premiums?

MS. ROSENBLATT: The providers who are going to be seeing a 17 percent decrease over the next few years are going to be looking for revenue elsewhere, which will drive up other parts of the health insurance sector.

MR. HACKBARTH: That may or may not be correct. I'd prefer not in this letter to broaden our issues, if you will, on this subject.

DR. ROWE: It's not in our best interest to have that included, Alice, because then Congress will say, good, somebody else will pay.

DR. NELSON: As a matter of fact, private payers often set their payment based on this, so actually it will have the reverse effect.

DR. ROWE: I don't think so.

DR. NEWHOUSE: And it presumes that doctors wouldn't start to treat Medicare patients like Medicaid patients.

MR. HACKBARTH: Let's stick with what we've got here.